DEPARTMENT OF HEALTH AND HUMAN SERVICES

Sep. 12 2011 10:38AM P 6

Fax No. :6158650321 HEALTH CARE FACILITY 09/08/2011 12:53 9655945739

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PRINTED: 09/07/2011 FORM APPROVED

TATEMENT ND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION	OMB NO (X3) DATE S COMPLI	URVEY
		445047	B. WING_		78 to 27	R-C
	ROVIDER OR SUPPLIE L GARDENS HEAL	TH AND REHABILITATION	3	REET ADDRESS, CITY, STATE, ZIP O 106 W DUE WEST AVE MADISON, TN 37115		06/2011
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE AGTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE BE APPROPRIATE	COMPLE DAT
{F 000}	A revisit was cor Health and Reha 6, 2011, following Compliance to re at F333 Scope at revealed the corr August 30, 2011, Jeopardy at F333 at a "D" as evider The "G" level cita citations at F157	npleted at Imperial Gardens bilitation Center on September acceptance of the Allegation of move the Immediate Jeopardy of Severity level "J". The revisective actions implemented removed the Immediate but non-compliance continuenced by the findings at F333, tion at F323 and the "D" level and F281 remain outstanding.	of it	F 000 Without admitting citations rendered, Imperial and Rehabilitation alleges compliance with all described by September 12, 2011.	Gardens Health	9/,
\$\$ = D	A facility must improve the result with the result with the result with the result or an interested to accident involving injury and has the intervention; a sign physical, mental, adeterioration in he status in either life clinical complications significantly (i.e., a existing form of the	mediately inform the resident; esident's physician; and If resident's legal representative amily member when there is an the resident which results in potential for requiring physicianticant change in the resident's proposocial status (i.e., a alth, mental, or psychosocial threatening conditions or poss); a need to alter treatment a need to discontinue an estiment due to adverse.	n S	F 157 Imperial Garden appropriate parties are notificated in a significant change in condition, a change in tradecision to transfer or dischar Resident # 11's family was 8/9/2011 of an elevated PT/first and when the second la obtained by the nurse on dudiscovery. The on-call Nurse was also notified as well as Physician by the nurse on dudiscovery. Additionally, to Physician was notified that sa medication error by the numaking the discovery. The fanotified that the resident transferred to the hospital	ed when there the resident's eatment, or a ge a resident. s notified on INR when the h results were ty making the se Practitioner the Attending ty making the he Attending ume day of the urse on duty unily was also was being	
	the resident from §483.12(a).	to commence a new form of ecision to transfer or discharge the facility as specified in		elevated PT/INR by the nurse the resident was transferred.	on duty when	9

Any deficiency statement ending with an exterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other cafeguards provide sufficient protection to the patients. (See instructions.) Except for hursing homes, the findings stated above are disclosable 90 days other transguards provide sufficient to the patients. (See institutions.) Except for hursing fromes, the mindings stated subvolute disclossable so days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclossable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

	. io . orrination in the	THE WILDIGHT TO OCT TO TOCO			OWR NO	. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER,	(X2) MUL A. BUILO	TIPLE CONSTRUCTION ING	(X3) DATE S	URVEY
		445047	B. WING		F 10 000 000 000 000 000 000 000 000 000	R-C 6/2011
NAME OF F	PROVIDER OR SUPPLIER		10	TREET ADDOCAG AND ATTACK THE CORN		
			l°	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
IMPERIA	L GARDENS HEALTI	H AND REHABILITATION		306 W DUE WEST AVE		
				MADISON, TN 37115		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PRECIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AR DEPICIENCY)	HOULD BE	(X5) COMPLETION DATE
{F 157}	Continued From pa	age 1	(C 457			
			{F 157	Attempts to communicate mis	h the famile.	
	the resident from the	ne facility as specified in	I	Attempts to communicate wit		
	§483.12(a).	18505		regarding the medication error		
				the family canceling a meeting		
	The facility must als	so promptly notify the resident		them on 8/9/2011; not answeri	ng the phone	
	and, if known, the r	esident's legal representative		on 8/11/2011; and hanging	up on the	
	or interested family	member when there is a	i	Administrator and Social Wor	ker during a	
	change in room or	roommate assignment as		conversation on 8/11/2011.	On this last	i
5	specified in §483.1	5(e)(2); or a change in				
	resident rights under	er Federal or State law or		attempt the family stated they		
	regulations as spec	ified in paragraph (b)(1) of		to talk with Imperial Garde	ns anymore	
8	this section.	med in paragraph (b)(1) of		about anything just prior to ha	nging up the	
				phone and ending the conversat	tion.	
	the address and ph	cord and periodically update one number of the resident's or interested family member.		Resident # 11 is no longer at th	e facility.	
	170	The second street,		Residents with any change i	n condition.	- 1
		1		medication error, or discharge	transfer to a	
	This REQUIREMEN	NT is not met as evidenced		hospital have the potential to be	effected.	
	Based on medical	record review and interview.		Beginning on August 16, 20	II all team	
	the facility failed to I	notify the family of a significant		leader nurses were in-serviced		
ļ	medication error for	one resident (#11) of		LPN and Nurse Educator	by IDON, an	i
Ī	thirty-one residents	reviewed.		notification to unprepriets	regarding	1
				notification to appropriate par	tics when a	1
	The findings include	ed;		resident has a change in cond	illion, This	
				began the one hundred percent		1
1	Resident #11 was a	dmitted to the facility on July		all licensed nursing staff. Th		
i	11, 2011, with diagn	loses including Diabetes.		was completed with all licen-		1
ŀ	Cerebral Artery Occ	tusion, Cerebral Infarction		August 22, 2011. New o		i
!	Chronic Anticoagula	ition, Hyperlipidemia, and		licensed staff members includ	ing licensed	
i	Diabetic Retinopathy	y.		agency staff will receive e	ducation on	Į.
	30 .0			notification to appropriate par	tics when a	
	Review of a Physicia	en's Order dated August 5.		resident has a change in condi	tion prior to	
ļ	2011, revealed."(Co	umadin) Warfarin Sodium 4		working on the units by the Nu	rse Educator	
i	mg (milligrams) Tab	let (medication that thins the		or designee.	Dancaron	1
	blood) by mouth at h	pedtime 9:00 p.m. Sat, Sun,		, and the same of]
16	Tues, and Thurs /S:	aturday, Sunday, Tuesday			Ti.	
	and Thursday) (Co	umadin) Warfarin Sodium				ł
i		omean) variatili soullili				
				No Company (Section 1997)	T [*]	1

From :VANGUARD_IMPERIAL-MANOR

Fax No. :6158650321 Sep. 12 2011 10:39AM P 8

09/08/2011 12:53 8655945739

HEALTH CARE FACILITY

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CUA	200 1		OMB NO	<u>0. 0938-0391</u>
ANDPLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	CULTIPLE CONSTRUCTION	(X3) DATE (BURVEY
		445047	ב, אזר	1G		R-C
NAME OF	PROVIDER OR SUPPLIER		'	trong and	09/	06/2011
IMPERI	AL GARDENS HEALT	H AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 300 W DUE WEST AVE		a a
(X4) 10	SUMMARY STA	ATEMENT OF DEFICIENCIES		MADISON, TN 37115		
PREFIX	REGULATORY OR L	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		MALKABA	COMPLETION DATE
	Medical record revidated August 11, 2 (equals) Coumadin (Monday, Wednesding Sun, Tues, Thus Albert 11, received Coulor (Licensed Practical orders, they just look the MAR (Medication gave the med. (Medication gave the med. (Medication errors (milligrams of coumading the family was notified medication errors (milligrams of coumading on August conference room, conotify the family of the Coumadin for three mg alternating with (483,20(k)(3)(i) SERV PROFESSIONAL STATE SERVICES PR	iew of the facility's investigation 011, revealed, "Order = 3 mg po (by mouth) M, W, F day, and Friday). Coumadin 4 ms, Sat (Sunday, Tuesday, urday), On 8/6/11, 8/7/11, and burnadin 7 mgThe LPNs Nurses) did not read the bleed at the empty spaces on on Administration Record), dication) and went on" Bew revealed no documentation led of the significant received seven addin for three consecutive of 17, 2011, at 2:10 p.m., in the confirmed the facility failed to the resident receiving 7 mg of days instead of Cournadin 3 coumadin 4 mg. VICES PROVIDED MEET FANDARDS and or arranged by the facility and standards of quality. T is not met as evidenced ecord review and interview, of the properties of the second review and interview, of the properties of the second review and interview, as medication for one (#31) is reviewed.	{F 1:	report daily. This report identifies who have a change in contreatment based on physician of IDON or designee will revie assure appropriate parties are in timely manner when such not warranted. The 24 hour automatically generated from the Charting System (ECS) Additionally, the IDON or reviews changes in resident contreatment in a stand up meeting Team Leaders and other members in the contreatment. If an appropriate parties with changes in contreatment, the IDON, Team Leader designee follows up with the aparties immediately. The IDON or designee tracks at these results.	designee ondition or ders. The w daily to otified in a iffication is report is electronic designee ondition or g with the designee ondition or g with the designee ondition or der Nurse of the designee ondition or der Nurse of the designee of the designee ondition or der Nurse of the designee of the de	
	A PERSON CONTRACTOR OF THE PROPERTY OF THE PRO	bsolete Even ID DESYCE				

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HEALTH CARE FACILITY

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DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 09/07/2011 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING R-C B. WING 445047 09/06/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE IMPERIAL GARDENS HEALTH AND REHABILITATION 306 W DUE WEST AVE MADISON, TN 37115 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (F 281) Continued From page 3 F 281 (F 281) Medications will be given according to Physicians' Orders and The findings included: professional standards of care, Resident #31 was admitted to the facility on May 11, 2011, and re-admitted on June 30, 2011, with A physicians' clarification order was diagnoses including Hypertension, Dementia, and written on August 19, 2011 regarding the Myocardial Infarction, Senna for resident # 31 to receive 2 Senna 8.6 mg tablets. The resident continues to Medical record review of a Physician's receive the correct dose of Senna. Re-admission Orders dated June 30, 2011, revealed, "Senna 15 mg (milligrams) Tablet by mouth bid (twice a day), 0800 (8:00 a.m.), 2000 Residents receiving medications have the (8:00 p.m.) for constipation." ability to be effected. On August 17-19, 2011 the IDON lead a team comprised of Medical record review of the Physician's LPNs, RNs, MDS RN, MDS LPNs to Recapitulation Orders for July and August, 2011, revealed, "Senna 15 mg Tablet by mouth bid. complete a medication match-back process to insure no other residents were affected. 8:00 a.m., 8:00 p.m. (Hold for diarrhea): For Constipation." On August 16, 2011, all team leader nurses Medical record review of the Medication were in-serviced by IDON, an LPN, and Administration Record dated July, 2 2011, through Nurse Educator regarding appropriate August 18, 2011, revealed, "Senna 15 mg Tablet medication passage including transcription by mouth bid. 8:00 a.m., 8:00 p.m..." of physician orders. This began the one hundred percent education to all licensed Observation of the medication dart on August 18, nursing staff. 2011, at 10:45 a.m., with the medication nurse The education was completed with all licensed staff on August (#7) on the west wing, revealed Senna 8.6 mg 22, 2011. New or returning licensed staff tablets in the cart. members including licensed agency staff

FORM CMS-2567(02-99) Previous Versions Obsolete

Interview with the medication nurse (#7) on the

west wing on August 18, 2011, at 10:45 a.m., in

Interview with the Restorative Nurse Assistant on

August 18, 2011, at 11:00 a.m., on the west wing. confirmed, "The resident received Senna 8.6 mg

the hall, revealed, "I have always given two tablets of Senna 8.6 mg (to resident #31),"

Event ID: OP5Y12

Facility ID TN1912

Additionally,

outside the facility.

If continuation sheet Page 4 of 1.2

will receive education on medication pass

prior to working on the units by the Nurse

conducted with licensed staff on 8/28/2011

through 8/30/3011 by clinical resources

onc-on-one demonstration" for accurate order entry was

Educator, IDON or designee.

From: VANGUARD_IMPERIAL-MANOR 8655945789 05/00/2011 17:23

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Sep. 12 2011 10:40AM P 10

MEALTH CARE FACILITY

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED OMB NO, 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A BUILDING COMPLETED 445047 B. WING R-C NAME OF PROVIDER OR SUPPLIER 09/06/2011 STREET ADDRESS, CITY, STATE, ZIP CODE IMPERIAL GARDENS HEALTH AND REHABILITATION 306 W DUE WEST AVE MADISON, TN 37115 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION PREFIX (X5) COMPLETION DATE REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) {F 281} Continued From page 4 are noted they will be corrected by the {F 281} bid, but on June 30, 2011, the admission nurse Nurse Educator, IDON or designee immediately to assure the resident does not entered Senna 15 mg bid into the computer get the incorrect medication. A medication (ECS-Electronic Computer System)." error report will be initiated by the person Interview with the MDS (Minimum Data Set) conducting the audit and the 1DON or Nurse #1 on August 20, 2011, at 9:10 a.m., in the designee will be notified. conference room, confirmed, "I called the Physician to validate the order for Senna 8.6 mg The results of the these audits are given to bid on June 30, 2011, but I failed to write the the IDON or designce. The IDON or order or put it in the computer. designee tracks and trends these results and reviews the overall effectiveness of the system and reviews the outcomes. The results of this tracking and trending are presented to the QI Team composed of the (F 323) 483.25(h) FREE OF ACCIDENT SS=G HAZARDS/SUPERVISION/DEVICES Medical Director. (F 323) DON. ADON, Administrator, Restorative Nurse, MDS Nurse, Therapy Manager, Dining Manager, The facility must ensure that the resident Activity Manager, Nurse Educator, Medical environment remains as free of accident hazards Records and Human Resources Manager at as is possible; and each resident receives adequate supervision and assistance devices to the QI meetings held monthly but no less than quarterly. prevent accidents. F 323 Residents will receive adequate supervision This REQUIREMENT is not met as evidenced and assistance devices to prevent accidents. by: Based on medical record review raview of facility provided documentation (investigation). Resident # 1 is transferred to bed according to her plan of care. observation, facility policy review, and interview, the facility failed to provide the assistance of a Prior to the incident the nurse aide involved two-person transfer or the use of a mechanical lift had been instructed on proper transfers and during a transfer for one resident (#1) of lifts, gait belts, and proper hody mechanics thirty-one residents reviewed. The facility's failure at various in-services provided by the to provide adequate assistance for resident #1 facility. resulted in a fractured tibia and fibula (Actual Harm).

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/07/2011

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			FORM	APPROVE
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUILD	TIPLE CONSTRUCTION	(X3) DATE 8 COMPLE	ETED
NAME OF E	PROVIDER OR SUPPLIER	445047	2, WING			R-C 16/2011
IMPERIA	L GARDENS HEALTH	AND REHABILITATION	5	TREET ADDRESS, CITY, STATE, ZIP OC 306 W DUE WEST AVE MADISON, TN 37115	DE OSTO	0/2011
(X4) ID PREFIX TAG	(CACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SUDINDE	COMPLETION DATE
{F 323}	Continued From pa	ge 5	{F 323	The nurse aide involved in the immediately suspended outcome of the investigation terminated.	pending the	
	Dementia, Hyperter Cardiovascular Acc Medical record revie Set) dated July 12, required total assist activities of dally living Review of the currer 2011, revealed, " with transfers" Review of the facility Technician) Care Care Control Care Care of 2011, revealed, " Review of the facility Technician) Care Care of 2011, revealed, " Review of the care of 2011, revealed, " Review of the facility Technician of the currer review revealed to the currer review of the facility 2011, revealed, "Currassist x (times) 2/metassistance of two or Medical record review	ew of the MDS (Minimum Data 2011, revealed the resident ance with transfers and all ang. In care plan dated May 14, Use gait belt when assisting of SCNT (Certified Nurse and (card that instructs the sthe resident) dated July 30, equires 2 people for a mobility and may use lift" It is investigation dated July 31, rent intervention: transfer chanical lift (transfer with the use of a mechanical lift)"		All residents being transferred be effected. All nurses' aides were trained Educator or designee Aug through August 11, 2011 lifting policy, resident care of care plans and transfers. Ne including any agency aides training on lifting policy, cards, resident care plans and to caring for residents by Educator or designee. Resident Care Cards are automatically from the reside in ECS. Nurse aides will check Care Cards prior to transferring assure they know how the residence they know how the residence of the Nurse Educator, Team Ledesignee for proper transfering using the appropriate people and equipment. These completed weekly X 3 weemonthly X 3 months.	f by the Nurse gust 1, 2011 regarding the cards, resident we nurse aides will receive resident care transfers prior to the Nurse e generated at Care Plans sk the resident to dident is to be monitored by aders or their rechniques te number of audits will be	
1	TYPE: other: left foot ransfer. DATE OF IN DF INCIDENT: 10:30 Description of Incider ped, left leg became	/leg caught in side rall during		The results of the these audits the IDON or designee. The designee tracks and trends these reviews the overall effective system and reviews the outer results of this tracking and	se results and eness of the comes. The	

presented to the Q1 Team composed of the

From : VANGUARD_IMPERIAL-MANOR 09/08/2011 12:53 8655945759

Fax No. :6158650321

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HEALTH CARE FACILITY

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMEN AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA	(New torrest			0.0938-039
	D. YORKECHON	IDENTIFICATION NUMBER:	A BUILDIN	TPLE CONSTRUCTION	(X3) DATE	SURVEY
		1	1	Nis	COMPLETED	
NAME OF	PROVIDER OR SUPPLIER	445047	B. WING_		P	R-C .
IMPERI	AL GARDENS HEALT	H AND REHABILITATION	1 9	REET ADDRESS, CITY, STATE, ZIP CO 306 W DUE WEST AVE MADISON, TN 37115	DE	06/2011
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	PLIALLE NO	(X5) COMPLETION DATE
	hearing a "POP" a between the rail ar 3.5 inch x 1.5 inch bruising. Swelling pleft lower anterior li room: POSSIBLE (INVOLVED" Medical record revidated July 30, 201 "transfer to(local Medical record revidated July 31, 201 is an oblique fractul with fracture fragme alignmentthere is fibular diaphysisT OsteopeniaThe fill although this is not Medical record reviel History and Physical revealed, "The papalpation about the (Resident's) compared palpation about the (Resident's) compared palpation about the severely twisted causing ments and also a signments are holding Medical record reviel and the severely twisted causing ments are holding Medical record reviel and the severely twisted causing ments are holding Medical record reviel and the severely twisted causing ments are holding Medical record reviel and the severely twisted causing ments are holding Medical record reviel and the severely twisted causing ments are holding Medical record reviel and the severely twisted causing ments are holding the severely twisted causing ments and also a severely twisted causing ments are holding the severely twisted causing the	resident's leg was This resulted in a raised area to left shin. No presentpain and swelling to legFIRST AID: emergency CAUSE:STAFF lew of a Physician's Order I, at 11:15 p.m., revealed, hospital)" ew of a Radiology Report I, revealed, "On the left there are of the distal third of the tibia lents in near anatomic also a fracture of the distal there is severe extensive bular fracture may be old, certain." ew of a Hospital Physician's I dated July 31, 2011, then thas mild tenderness to left mid shaft tibia. It ments are very soft and dent) has no pain" w of the hospital discharge lift and the lift and t	{F 323}	Medical Director, DON Administrator, Restorative Nurse, Therapy Manager, Dini Activity Manager, Nurse Educi Records and Human Resource: the QI meetings held monthly than quarterly.	I, ADON, Nurse, MDS ing Manager, ator, Medical	
M CMS-2567	(02-99) Previous Versions C	Number 1			ł	1

From :VANGUARD_IMPERIAL-MANOR 09/08/2011 12:53 86559457\$9

Fax No. :6158650321

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HEALTH CARE FACILITY

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X	1) PROVIDER/SUPPLIER/CLIA			OMB NO	<u>0.</u> 0938 - 039
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION	(X3) DATE S	
	445047	B. WING			R-C
NAME OF PROVIDER OR SUPPLIER IMPERIAL GARDENS HEALTH A		306	ET ADDRESS, CITY, STATE 8 W DUE WEST AVE ADISON, TN 37115		06/2011
CEACH DEFICIENCY M	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	COMPLETION DATE
Review of the facility's 1, 2011, revealed, "Retransferred from the swhen the left leg becarails. The side rails we CNT reported hearing (resident) onto the bechurse) was immediate was transferred to(In determined that(resident one-tring or the facility's 31, 2011, of an intervice (Registered Nurse) with the recident on July 20 asked (CNT) if CNT with were supposed to transwhy (CNT) attempted to (CNT) stated, "(Reside and had been cooperabusy and (CNT) though alone" Review of the facility's 2011, revealed, "(The Cresident) reported to be status of the resident had been status of the reside	investigation dated August esident was being hower chair to the bed me entangled in the side a sound when she lowered it. The RN (Registered ely notified and the resident local hospital) where it was dent) had fractures of the ribia and fibula(resident) cility the following documentation dated July ew conducted by a RN in the CNT that transferred in a good mood five and everyone else was not (CNT) could dolt investigation dated July 31. CNT who transferred the element of the transfer double of the transfer double of the decision to dependently(CNT) also a good endently which in later and everyone else was not (CNT) also a good endently(CNT) also a good endently which in later and element e				

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HEALTH CARE FACILITY

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID

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MAKE OF PROVIDER OR SUPPLIER MPERIAL GARDENS HEALTH AND REHABILITATION SUMMARY STATEMENT OF DEPTOISNINGS SUMMADISON, TN 37115 DEPONDER'S PLAN OF CORRECTION FREDUCTION OF USC IDENTIFING MECHANICAL FREDUCTION OF USC IDENTIFINE INTO IDENTIFICATION OF USC IDENTIFICATION FREDUCTION OF USC IDENTIFINE INTO IDENTIFICATION FREDUCTION OF USC IDENTIFICATION FREDUCTION O	MAKE OF PROVIDER OR SUPPLIER MPERIAL GARDENS HEALTH AND REHABILITATION STREET ADDRESS, CITY, STATE, 2IP CODE 306 W DUE WEST AVE MADISON, TN 37115 SUBJULIARY STATEMENT OF DEPCIPACIONALS FRED FRED FRED FRED FRED FRED FRED FRED	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	- P		(X3) DATE	SURVEY
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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMEN	T OF DEFICIENCIES	WAY BEEN TO SERVICES			OMB NO	. 0938-0391
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	This REQUIREMED by: Based on survey the facility failed to resulting in a critical (Protime/Internation test used to determine the sused to determine the sused to determine the sused to determine the facility provided Allegation of Complements actions implements the immediate Jeonon-compliance con Validation of the Crompliance was as a record review and in The facility provided the summediate of the summediate of the facility provided the summediate of the summediate of the facility provided the summediate of the summediat	nsure that residents are free of dication errors, INT is not met as evidenced results dated August 20, 2011, prevent a significant med error al PT/INR nal Normalization Ratio-lab nine therapeutic levels for dications) and hospitalization urteen residents receiving edication. Indication and acceptable Credible pliance with a compliance date of Arevisit completed on converted and acceptable corrective and August 20, 2011.	{F 3:	The IDON continued the on 8-10-2011 by reviewing on Coumadin therapy and of alternating patterns we Physician's orders, patterns means medication be administered on diffand/or medication doses to different times. (i.e. Coumonday, Wednesday, Friding Saturday, Sunday, Thursday). The findings of investigation were report Administrator and the Improvement Coordinator August 10, 2011. The transcribed the physician or use the appropriate order Therefore, the alternating of medication were not corrective MAR. The Registered Nurse who the physician order on received a written procorrection notice by the IDO 2011 for failing to ensure the order was clearly transcribed Electronic Charting Systems.	y all residents I the process when writing Alternating as ordered to Terent days be given at umadin 3mg day and/or 4 Tuesday, If the facility ted to the e Quality (QIC) on nurse who der failed to or structure, doses of the ethy sent to transcribed 8-6-2011 berformance N on 8-11- e physician ed into the em (ECS), immediate 8-11-2011	
	validation was revie	w of facility tools used to		Electronic Charting System ((ECC) and	

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HEALTH CARE FACILITY

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF PERCEION DENTIFICATION NUMBER ALBIRDING DESCRIPTION	STATEMENT	TOF DEFICIENCIES	100		<u></u>		OMB NO	. 0938-0391
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(F 333) Continued From page 10 document ongoing monitoring of verification of Physician orders to the Medication Administration Records and accuracy of transcription of administration administration, administration, administration, administration, administration, administration, administration, administration administration administration process, and had completed competencies for medication administration administration physician orders and head completed competencies for medication administration administration Records revealed the orders were entered correctly into the Electronic Charting System. Review of ten resident's (#1, 2, 3, 4, 5, 6, 7, 8, 9, 10) physician orders and Medication Administration Records revealed the orders were entered correctly into the Electronic Charting Systems and were confirmed by two nurses. Observation of a Medication Pass on September 6, 2011, from 8:00 p.m9:00 p.m. of three residents (#4, 5, 6) confirmed accurate administration of Cournedin and other medications. The facility remains out of compliance until it provides an acceptable plan of correction to include the continued monitoring to ensure the deficient practice does not recour and the facility's corrective measures could be reviewed and evaluated by the Quality Assurance Omnittee. PROVIDENCE PLANCE CORPROTOM ACTION GROWAGE (READ CORPRETION (READ TOOR) CONTROLLED (PASSION TOOR) In the incident bassure that it entered correctly. The two LPN's involved in the incident bassure that it entered correctly. The two LPN's involved in the incident bassure that it entered correctly. The two LPN's involved in the incident bassure that it entered correctly. The two LPN's involved in the incident bassure that it entered correctly. The two LPN's involved in the incident bassure that it entered correctly. The two LPN's involved in the incident bassure that it entered co				ABILITATION	1 3	306 W DUE WEST AVE		70.2017
document ongoing monitoring of varification of medication orders, accuracy of transcription of Physician orders to the Medication Administration Records and accuracy of the medication administration. Interview with seven licensed nurses and units confirmed the licensed nurses had been inserviced on Coumadin proters and administration, admission and readmission order verification process, and had completed competencies for medication administration administration administration physician orders into the Electronic Chariting System. Review of ton resident's (#1, 2, 3, 4, 5, 6, 7, 8, 9, 10) physician orders and Medication Administration of Records revealed the orders were entered correctly into the Electronic Chariting Systems and were confirmed by two nurses. Observation of a Medication Pass on September 6, 2011, from 8:00 p.m9:00 p.m. of three resident's (#4, 5, 6) confirmed accurate administration of Coumadin and other medications. The facility remains out of compliance until it provides an acceptable plan of correction to include the continued monitoring to ensure the deficient practice does not reoccur and the facility's corrective measures could be reviewed and evaluated by the Quality Assurance The facility remains out of compliance until it provides an acceptable plan of correction to include the continued monitoring to ensure the deficient practice does not reoccur and the facility's corrective measures could be reviewed and evaluated by the Quality Assurance The facility's corrective measures could be reviewed and evaluated by the Quality Assurance The facility's corrective measures could be reviewed and evaluated by the Quality Assurance The facility's corrective measures could be reviewed and evaluated by the Quality Assurance The facility is the facility of the facility wide by the IDON. This process was conducted by a Licensed Practical Nurse (LPN) and the IDON. This process checked the physician orders in the electronic charting system (ECS) and matched	PREFIX	1 CAUM DEFICIENC	Y MUST BE DE	SECEDED BY CITY	ID PRÉFIX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF	HOID BE	COMPLETION
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PRINTED: 09/07/2011

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED

STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY A. BUILDING COMPLETED 445047 B. WING R-C NAME OF PROVIDER OR SUPPLIER 09/06/2011 STREET ADDRESS, CITY, STATE, ZIP CODE IMPERIAL GARDENS HEALTH AND REHABILITATION 306 W DUE WEST AVE MADISON, TN 37115 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE ID REGULATORY OR LSC IDENTIFYING INEGRMATION) PREFIX (X5) COMPLETION DATE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY {F 333} transcription {F 333} errors. No other discrepancies were found. Beginning August 17, 2011 as part of ongoing quality improvement this process was repeated facility wide by MDS RN, MDS LPN, Staff RNs, Staff LPN Unit Clerk, Admission Nurse, LPN Medication Managers and Contract LPN lead by the IDON. This team audited physician orders, MARs and medications for all residents. The process checked the written physician orders on the medical record against the physician orders in the electronic charting system (ECS). Then, the physician orders were matched to the MAR and checked against the medications available in the medication carts. The only discrepancy noted was for one resident and one medication that had a start/stop date with the start date starting one day late. The physician was notified by the LPN conducting the audit and the physician extended the period of time for the medication for one day. This audit process was completed on August 19, 2011. The 24 hour report automatically pulls all new physician medication orders for the previous day to the 24 hour report.

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This 24 hour report is utilized to identify all new physician medication

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HEALTH CARE FACILITY

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DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 09/07/2011 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING B. WING R-C 445047 NAME OF PROVIDER OR SUPPLIER 09/06/2011 STREET ADDRESS, CITY, STATE, ZIP CODE IMPERIAL GARDENS HEALTH AND REHABILITATION 306 W DUE WEST AVE MADISON, TN 37115 SUMMARY STATEMENT OF DEFICIENCIES
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REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE PREFIX 10 PREFIX DATE DATE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) {F 333} orders written. All new physicians' {F 333} medication orders entered by the licensed nurse are reviewed daily for appropriate format in the ECS by the IDON, or designee. This review is completed within 24 hours of any newly transcribed medication order. This includes the name of the drug, the dosage, the route, the frequency, the time and the reason (diagnosis) for the medication. Any errors inconsistencies in the format of the medication order are immediately corrected by the IDON or designee. On January 7, 2011 the process for a Medication Pass Exception Report was initiated. This Medication Exception Report identifies resident whose medications were omitted and the reason for such. The Medication Pass Exception Report is automatically generated from the ECS and is printed after each medication pass by the RN/LPN Medication Nurse. This report is reviewed with the RN Team Leader and RN/LPN Medication Nurse at the end of each shift. Additionally, it is reviewed daily (within 24 hours of completion) by the

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Facility ID: TN1812

IDON or designee. The reason for any medication omitted is written on this report and in the nurses' notes. If an error is detected, the Team Leader Nurse immediately, at the time of

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hospital are reviewed with the attending physician by the Corporate Admission Coordinator or designee and

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/07/2011 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING R-C B. WING 445047 NAME OF PROVIDER OR SUPPLIER 09/06/2011 STREET ADDRESS, CITY, STATE, ZIP CODE IMPERIAL GARDENS HEALTH AND REHABILITATION 306 W DUE WEST AVE MADISON, TN 37115 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR USC IDENTIFYING INEGENATION)

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION DATE PREFIX TAG DEFICIENCY either confirmed or revised by the {F 333} attending physician. The confirmation or revision of recommendations takes place upon receipt of the orders from transferring facility confirmation that the resident is indeed being admitted. The confirmed admission orders are then entered into the Physicians' Orders in the ECS by Corporate RNAdmission Coordinator or designee. These orders are double checked by a RN/LPN upon admission of the resident into the facility to assure that no inconsistencies are present and that the order entry process was completed accurately and timely. This double check process continues by a RN/LPN per facility process, monitoring the MAR against the physicians' orders on a 24 hour basis, seven days a week. For residents who are readmitted, all physicians' orders are discontinued by Corporate RN Admission Coordinator or designee just prior to entering all new orders into the ECS. Therefore, all physicians' orders should reflect the date of the readmission to the facility. The Administrator and/or IDON are notified of any after five pm or weekend admissions by the Corporate RN Admission Nurse, Facility Admission Nurse, Social Worker or RN Team Leader or designee to assure the appropriate

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HEALTH CARE FACILITY

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/07/2011 FORM APPROVED

TOR MEDICARE	E & MEDICAID SERVICES		FORM APPROVED
	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	OMB NO. 0938-0391
	I I I I I I I I I I I I I I I I I I I	A. BUILDING	COMPLETED
NAME OF PROVIDED OF	445047	B. WING	R-C
NAME OF PROVIDER OR SUPPLIER	3000 3 3	STREET ADDRESS, CITY, STATE, EIP CO	09/05/2011
IMPERIAL GARDENS HEALT		TODRESS, CITY, STATE, EIP CO	DDE .

IMPERIAL (X4) ID	GARDENS HEALTH AND RES	\$1. 80		TREET ADDRESS, CITY, STATE, EIP CODE 306 W DUE WEST AVE MADISON, TN 37115	0.2011
PREFIX TAG	SUMMARY STATEMENT OF (EACH DEFICIENCY MUST BE P REGULATORY OR LSC IDENTIFY		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION COMPLETION DATE
{F 333}			{F 333	follow up is implemented. This notification generally occurs before the resident arrives and is at a minimum within four hours after the resident has been admitted to the facility. If the Corporate RN is unavailable to initiate the usual process, the RN/LPN Team Leader enters the physician medication orders. A second RN/LPN Team Leader reviews the medication orders and matches it to the MAR. Then, a RN/LPN Medication Nurse conducts a final review matching the physicians medication orders to the MAR prior to the medications being administered. The IDON instructed the RN Team Leaders and LPN involved on this process on August 27, 2011. The Administrator or IDON reviews the process with the team to assure no medication transcription errors occur and the process is followed. This notification process began on January 16, 2011 and was revised on August 27, 2011 to assure that the order double check process could occur timely, within 24 hours from admission and the process is ongoing. On August 16, 2011, all team leader nurses were in-serviced by IDON, an LPN, and Nurse Educator regarding physician order entry including alternating doses and one time only doses of medications in the ECS are	

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doses of medications in the ECS, as

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDIDAID SERVICES

PRINTED: 09/07/2011

FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 445047 B. WING R-C NAME OF PROVIDER OR SUPPLIER 09/06/2011 STREET ADDRESS, CITY, STATE, ZIP CODE IMPERIAL GARDENS HEALTH AND REHABILITATION 308 WIDUE WEST AVE MADISON, TN 37115 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST SE PRECEDED BY FULL (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX DX5 COMPLETION DATE DEFICIENCY {F 333} well as lab monitoring and medication {F 333} administration. This began the one hundred percent education to all licensed nursing staff. The education was completed with all licensed staff on August 22, 2011. Additionally. licensed nurses are trained on ECS during orientation by the Nurse Educator or designee. This includes how to enter physician orders. In order to assist licensed nurses, ECS reference cards were initiated on August 28, 2011 These reference cards are located on each nursing wing with instructions on how to use the ECS system. Included in this is a card on how to enter physician medication orders into the ECS system. These reference cards provide step-by-step instructions to the licensed nursing staff regarding ECS. These cards follow the one-on-one return demonstration education, which was provided by the Corporate RN and her designee and reinforces this education (see below) Additionally, medication pass audits are being conducted weekly on licensed nursing staff including licensed nursing agency staff by the IDON, Nurse Educator and RN Team Leaders. This audit tool was revised in April, 2011 and weekly audits began on August 8, 2011. These audits check to assure the licensed nurse identifies the resident

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PRINTED: 09/07/2011 FORM APPROVED

STATISTICAL MEDICAR	E & MEDICAID SERVICES		FORM APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(V2) 1410 770	OMB NO. 0936-0391
THE OF CORRECTION	DENTIFICATION NUMBER:	W = 7 MIDETIFEE CONSTRUCTION	(X3) DATE SURVEY
64		A. BUILDING	COMPLETED
	445047	B. WING	R-C
NAME OF PROVIDER OR SUPPLIER			09/06/2011
IMPERIAL GARDENS HEALT	H AND DELLARIE	STREET ADDRESS, CITY, STATE, ZIP CODE	

(X4) ID	GARDENS HEALTH AND REHA	1	REET ADDRESS, CITY, STATE, ZIP CODE 306 W DUE WEST AVE MADISON, TN 37115	
PREFIX TAG	SUMMARY STATEMENT OF D (EACH DEFICIENCY MUST BE PRE REGULATORY OR LSC IDENTIFYIN	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
{F 333}		(F 333)	prior to administering medication, and that the correct medication is given to the resident in the correct dose, by the correct route and at the right time. The monitor ensures residents who receive medications that need monitoring are reviewed or assessed prior to the administration of the medication (i.e. Digoxin, Coumadin, etc.). When applicable, lab values are checked by the RN/LPN prior to medications being given in accordance with physician orders. A one on one in service "return demonstration for accurate order entry" was conducted with the licensed staff on 8-28 through 8-30-2011 by clinical resources outside the facility. This included the entry of a Coumadin order that required a special pattern setup, an antibiotic order, a once monthly order and an every other day order that started on a future date. The licensed nurse was observed as the orders were written, education provided when needed and checked off for competency when completed. Contract labor registered nurses and licensed nurses working in the facility during the time frame of the above listed in services also participated in the educational process.	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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AND PLAN OF	CORRECTION	(X1) PROVIDER	RYSUPPLIER/CLIA ATION NUMBER:	(X2) MULT	TIPLE CONSTRUCTION		7. 0938-039
-			MICH HOMBER:	A. BUILDI		(X3) DATE :	ETED
NOVE DE LE			445047	B. WING_			R-¢ .
1	OVIDER OR SUPPLIE			I ST	REET ADDRESS SITV DAVID	09/1	06/2011
IMPERIAL	GARDENS HEAL	TH AND REHAL	BILITATION		REET ADDRESS, CITY, STATE, ZIP CO 306 W DUE WEST AVE	DE	
(X4) ID					MADISON, TN 37115		
PREFIX		TATEMENT OF DE		QI QI	PROVIDER'S PLAN OF COM	PECTION	
TAG	REGULATORY OF	LSC IDENTIFYING	INSORMATION	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEPICIENCY)	CHAIR B BE	COMPLETIO DATE
{F 333}				(F 333)	New or returning lice	ensed staff	
1					members including licen staff will receive one-on-or	sed agency	
1					with return demonstration	e education	1
}					order entry as stated above	for accurate	
1					checked off for compete	and will be	
			Ì		working on the units by	the Nurse	!
					Educator, IDON, or designe	e.	
					On September 9, 2011 the	regults of	
. [audits were taken to the OI	Committee	
			i		The committee determine	d that the	
- 1					Nurse Educator or design	nce is to	
1					continue the training w	ith nurses	
i			The state of the s	*	(including agency nur	ses) on	
					medication pass exception	on renor	
					verification of admission/r	codmission	
					orders during regular hours	with two	
ļ				1	nurses, ventio	ation of	
					admission/readmission orde	rs after 5	
			ļ		pm or during weekends withan 2 liganood	th no less	
į					than 2 licensed nurses, physician orders into the	entering	
ļ			[Charting System, and	Electronia	
}			i		System Referen	ice Cardo	
				Į.	before working on the i	mite This	
,					practice will be ongoing. A	ditionally	
i i					the Nurse Educator or desi	unce ic to	
į					continue with medication na-	se audita at	
}					reast twice in September an	d then Di	
			ļ	-	monthly medication pass an	dits on all	
1.				-	nuises (including agency) f	or no loss	İ
1.				!	man two additional mon	the This	
					recommendation was approv	ed by the	
RM DMS-2567(0)	2-pp) Previous Version	• Clemelar			Of Committee and the Adi	ninistrator	
		- Oprojete	Event (D) DP0Y12	Facil	monitor'	continued	